

Psychological Aspects of Medical Prescription

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■ *Medication possesses a potential for therapeutic efficacy far beyond its chemical capacity if prescribed in ways which enlist patients' personality traits in a therapeutic direction. "Prescription" in this sense includes the physician's attitude (as the patient sees it) and subtleties in the way he fits his instructions to the kind of patient he is dealing with. This presentation deals with four kinds of patients—widely different in what they need from the physician—for whom some therapeutic "placebo" effect of prescription can be brought to bear:*

- 1. Patients who are unduly fearful about what is wrong with them, and who look to the physician for calm sureness.*
- 2. Systematic, controlled, organized patients, who like to share in their own medical management.*
- 3. Patients who are excessively depressed about being sick.*
- 4. Patients for whom "nothing works," but who can be helped by a physician who is willing to accept "failure" in dealing with them.*

For all of them, careful appraisal and sophisticated treatment are necessary.

IF AS MUCH EFFORT were made to enhance the "placebo effect" in clinical practice as is made to minimize it in research, subjective benefits from medication would be greatly increased. I am using the term *placebo effect* to designate the vector resultant of all the psychological factors entailed in the taking of medication. This includes the factors that reduce as well as those that enhance the basic chemical effects, and the factors in clinicians as well as those in patients.

The enthusiasm felt for a new drug is recognized

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as a reason for initial over-estimation of the value of such a drug. If this degree of enthusiasm could be maintained, subsequent use of the drug might be just as successful as the initial use had been. However, replication of initial studies by skeptical researchers usually indicates much less value in the drug, and this tends to dampen the enthusiasm of the clinical community. So it is inevitable that most medications will not produce therapeutic effects as much beyond their chemical capacity as it is theoretically possible for them to produce.

This being so, the attitude of clinicians toward the drugs they use is controlled in large measure

by the current state of medical knowledge and opinion. It is therefore more useful to turn to factors within patients which affect the results of medication.

General Principles

Physicians generally recognize that their patients do not unfailingly have prescriptions filled and do not always take medicines as they have been instructed to do. Experience has taught that it is well to ask explicitly whether and how the patient is taking prescribed drugs and to deal with the causes of his failure to do so.

Factors related to medication reveal themselves during the taking of the history and in subsequent contacts with the patient. All people have certain attitudes toward drugs in general and other attitudes toward certain kinds of drugs. If such attitudes are not mentioned spontaneously, they come to light during discussion of previous illnesses and medications which have been self-prescribed or professionally administered in the past. Patients who share the common belief that oral medications are generally weak while injectables are potent will usually indicate this, along with prejudices about liquid versus tablet forms of medication. More importantly, patients may reveal that they equate the taking of medications with weakness and "pampering." They may "react badly" to almost all drugs. Or they may have always needed larger than average doses (or smaller than average doses) of any medications prescribed. This list could be expanded considerably.

If the patient recounts, with some degree of pride, that all the medications that others have prescribed for him have failed to do any good whatsoever, it is a naive physician who writes out a prescription for a new drug without dealing with the underlying mental set of the patient. If the patient has always had "bad reactions" to normal doses of medications, the experienced physician will not only begin with a drug in smaller than normal doses; he will also tell the patient that he has done so. If the medication to be prescribed is one that looks like a previously tried and ineffective one, it is well to let the patient know they are not the same.

The number of individual problems possible around the taking of medication is tremendous. Most problems are soluble by means of ordinary medical judgment—provided the physician recognizes that they exist.

Particular Kinds of Patients

Apart from general attitudes, the nature of a patient's personality should be taken into consideration in prescribing medication. But such considerations often require more than average sophistication. It is generally known, for instance, that patients whose personality is of the "hysterical" type are suggestible. Physicians may, therefore, tend to prescribe medication for such patients with especial efforts to suggest that it will be effective. However the medication may be a dismal failure, in spite of the attempt at suggestion. The suggestible patient tends to react to the physician's attitude as the patient perceives it from many kinds of clues, not just from reassuring or encouraging words. Thus, an underlying doubt about the probable usefulness of the medication may be reflected by an inadvertent facial expression; in such a case, the *real* suggestion may have been that the medication would *not* work. Because the physician may be unable to control his non-verbal expression of expectation and attitude, as well as for other reasons, mere verbal reassurance is often useless in suggesting anything. Hence, in the following discussion of particular types of patients, if it is noted that a particular attitude will be helpful, this should be taken to mean that the attitude will be helpful if it is *truly* held by the physician, not just if he *pretends* that he holds it.

The Anxious Patient

The term *anxious* is meant to denote patients who are unduly fearful about what is wrong with them, not necessarily patients who have a specific neurotic anxiety reaction. Such patients do best with a physician who is himself calm. Anxiety tends to be infectious; so, in such patients, is uncertainty. This is not meant to recommend a pretense of knowledge as to what is wrong and what should be done. But the anxious patient will respond well to the physician's confidence that he will ultimately be able to help the patient. I do not intend to recommend a casual or superficial history-taking or examination. On the contrary, with the anxious patient, the more thorough these are, the better. However, the casual attitude will have a reassuring effect *after* the thorough evaluation. Since the anxious patient tends to be pre-occupied with his state of health, he will generally be frightened by detailed descriptions of what may be wrong, what is to be done and what may complicate treatment. For such patients, the simpler the information the more reassuring it will be.

The more complex the information, the more there will be to be worried about, and the worry may well aggravate the primary illness.

With such patients the same principles apply to prescription of medicines. The therapeutic effects and any prominent side-effects may be mentioned briefly and simply but should not be described in detail. If several medications may have to be tried, the patient should be told this at the outset to prevent increased anxiety if the first medication is not effective enough. For the anxious patient, it is often well, if the nature of the illness and the medication permit, to allow some leeway in dosage. The anxious person tends to feel in a state of entrapment, and his anxiety is increased by anything that implies "there is no way out." In the case of medication, the possibility of an extra dose represents a "way out." Since one facet of entrapment is unobtainability of something that is needed, the physician will do well to emphasize that he is available to the patient, in person or by phone, in case of need. The more available the physician is felt to be, the less likely the anxious patient is to call him.

The Compulsive Patient

The term *compulsive* is meant to designate the particularly systematic, controlled, organized patient, not necessarily the patient with obsessive-compulsive neurotic symptoms. Such patients require management almost opposite to that recommended for the anxious patient. The more detailed and organized the information that the physician gives them about their illnesses and medications, the better they do. For such patients, it is often best that they know the name of the medication and a reasonable amount of detail of its expected effects and side-effects. If the patient asks questions about safety, chemical features or relationship to other medications, the physician will do well to answer in as much detail as is appropriate to the patient's capacity to understand technical information. The schedule of dosage should be well organized and specific. With such patients, a drug should be taken "before meals" or "after meals" rather than "around mealtimes."

However, it should also be kept in mind that "control" is an important area for such patients. They may feel that taking medication represents "being controlled." Even so, a patient of this order may do well on medication if the physician can find a way of giving him some share in manage-

ment of the medicinal regimen. This assignment of responsibility to the patient may be in the nature of permitting him to participate in decisions about dosage and schedule. If such decisions are to be shared by the patient, the basis for them should be laid down specifically in terms of symptoms or signs which are to guide his decision.

The compulsive patient does not need to have a physician who manifests the kind of certainty that was described as desirable for the anxious patient. He may do even better with a physician who manifests doubt, provided the physician has an organized, systematic, way of going about investigating the unknowns. The kind of calm certainty which reassures the anxious patient may suggest to the compulsive patient that the physician is a careless person who may be ignoring serious and dangerous matters in connection with his health.

The Depressed Patient

As with the other terms used, *depressed* is not meant necessarily to imply clinical depressive illness, but rather an excessive degree of depressive feeling about being sick. Seemingly paradoxically, one warning of possible depressive reaction to illness is an excessively minimizing attitude toward it. The potentially depressed patient may be so threatened by his underlying depression that he attempts to minimize his illnesses. The management of such a patient is most difficult. One form of minimization is neglecting to take prescribed medication. To force an awareness of the severity of his illness on the patient may precipitate a severe depressive reaction. Ignoring the minimization permits the patient to ignore the medication. The physician must walk a fine line in such cases. It is best if the patient can accept the fact of the illness in gradual degrees. One way to do this is by an insistence on the importance of the medication or other prescribed treatment procedures. It is often helpful here to enlist responsible family members in enforcing the treatment regimen.

For the frankly depressed patient, the management approach is less difficult, apart from the need to be alert for serious frank depressive *illness*. If this seems to be threatening, it is urgent to assess the suicide risk. Unless the physician is experienced in making such assessments, psychiatric consultation is desirable.

As physicians with experience in managing depressed patients have learned, it is most important not to minimize their depression. Family, friends

or less sophisticated professional practitioners often try to cheer up depressed patients by telling them there is very little wrong with them. This tends to aggravate depressive reactions rather than to alleviate them.

Depressed patients do better with physicians who accept their view of themselves as ill, and who recognize the problem which being ill constitutes for the patient. The physician may (and, indeed, generally should) reassure the patient that he will eventually recover, if this is the case. But he should not minimize the present existence of the depressed feeling as part of the reassurance about the future. Medications should be prescribed with precision, much as for the compulsive sort of patient. However, with the depressed patient, control of the regimen should remain with the physician. The depressed patient is burdened by responsibility and should not have the burden aggravated by being asked to share in the responsibility for treatment. The expected effects and possible side-effects of medication may be conveyed to the patient, but, as with the anxious patient, this information should not be unduly detailed.

It is also important to warn depressed patients that the medication will probably take some little time to be effective. The more depressed a patient is, the more likely he is to underestimate the degree of objective improvement he undergoes in treatment. Thus he may appear to others to be improving without his recognizing this himself. To tell a depressed patient he is improving when he himself cannot recognize the improvement has the same effect as does minimizing his illness originally: It aggravates the depressive element.

It is well to caution overenthusiastic family members not to minimize the seriousness of either the primary physical illness or the depressive element. Otherwise they may be undoing at home what the physician is trying to accomplish in his treatment program. If there is a question of potential suicide, it is well to entrust the physical custody of the medication to a relative and not to the patient.

The Patient for Whom Nothing Works

There is a particular kind of patient who needs to be considered separately. Every practicing physician has had a number like him. This is the patient for whom nothing works. He tends to go from physician to physician, receiving from each a series of medications. All are, as have been all preceding, utter failures. Such patients are often the targets

of medical wrath for their intransigence. Psychiatrists see such patients at times. They may have the satisfaction of affixing a codable term to the patient's illness, but they are most often equally unable to cure it. These patients are sometimes called "hypochondriacs" and sometimes "intractable" and sometimes by other names. Their shibboleth is that the history reveals multiple failures in attempted treatment of a symptom or symptoms. They are treatable within certain limits—by physicians who are willing to "fail" in order to succeed. These are patients who, for varying reasons and in varying ways, must remain ill in spite of treatment. Thus, the treatment will "fail" in the sense that it will not make the patient symptom-free. However, such patients do not "enjoy" their illnesses in any conscious way. Psychiatrists who speak of the enjoyment of illness (or of other distressing situations) mean only that there is a need for the unpleasant state which outweighs its unpleasantness. Any "enjoyment" of the unpleasantness is quite outside the patient's awareness. In many such cases, if not in most, the symptoms represent a way of maintaining some sort of interpersonal relationships which (in the patient's mind) depend on his being sick. Among others, the relationship with the physician himself can be an important one for such patients.

The successful physician with such patients is the one who can permit the patient to retain his symptoms, while continuing to treat him. "Treatment" here means maintaining the physician-patient relationship as one within which the patient can seek help and obtain emotional support without having to be "well." Physicians tend to hope for symptom-relief in their patients, but for the "intractable patient" this expectation is unreasonable. The physician must not come to look upon the patient as a "bad" patient just because he remains ill. Once the demand for symptom relief is abandoned, it is surprising how easy it is to treat such patients.

There are several elements to treatment of patients of this kind. First there is the physician's mental set, as noted above. Once it is assumed by the physician, it will be communicated to the patient without having to be put into so many words. Other things follow from this. When medication is prescribed, it need not be presented as something that will make the patient well, but as something that "may help" or as something that is "worth trying." There need be no implication that

failure of the medication equals non-cooperation by the patient. A trial of several medications may be helpful. Although it may be necessary that no medication be effective in cure, it may be quite possible for the patient to accept one as more helpful than others. If maximum relief of symptoms has been achieved, there should be some consensus of satisfaction with the result by physician and patient.

In the foregoing discussion there is implication that medications will be used, but that is not to say that they should be used just for the sake of prescribing something. For some patients, it may be enough simply that the physician "follow" the patient's progress, listen to the course of his difficulties, and be alert to the possible development of organic disease which does require more active and specific treatment. It has been said before, but bears repeating, that hypochondriasis does not provide prophylaxis against organic diseases.

There are patients for whom medication may be advisable, even without organic indications for it. There are patients who can maintain a physician-patient relationship *only* around the prescription of medication. The physician need not be ashamed of using such an approach. On the other hand, such "placebo" medication should be prescribed when a careful evaluation of the situation indicates it is truly indicated, not just for the sake of something to do.

Warning

A paper such as this one is necessarily artificial, in that it discusses psychological traits as if they appeared in pure culture. This rarely happens in real life. Many patients have combinations of the factors discussed. A usually compulsive person may come to medical attention with a reaction of depression associated with a particular illness. A normally depressive kind of person may be in a state of anxiety related to the particular illness from which he is currently suffering. In cases such as these, the management should be addressed to the newer reaction that is superimposed upon the pervading one. Such newer psychological reactions more often represent a neurotic component of illness; and they are, for this reason, more disturbing and difficult for the patient to cope with. Medical management should be directed toward the approaches which are most therapeutic with regard to the neurotic decompensation. If the unfamiliar sort of emotional reaction subsides and is replaced by the more lifelong personality trait, the management may be altered to conform with the patient's dominant psychological state.

Other than for situations such as these, where a patient normally manifests a personality in which two elements are combined the physician must use his best judgment in blending the approaches suggested.

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